TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
INDUSTRIAL SOLUTIONS NETWORK

Respondent Name
CITY OF EL PASO

MFDR Tracking Number
M4-16-0350-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
October 9, 2015

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Dr. Zoldos referral came to Industrial Solutions Network from one of our contracted clinics to obtain authorization . . . Our authorization department was notified by the Adjuster . . . that the initial visit was authorized based on reasonable and medical necessity . . . and all other visits must be approved by IMO (Injury Mgmt Organization). She also made it aware at the time that this is a TX claim, ISN handles AZ claims and is not acquainted with Texas guidelines. IMO was contacted and sent an authorization request for 12 additional visits. On 7/14/15 we received an email from IMO, attached was a Determination letter approving 12 sessions . . . We recently received partial payment for all 5 dos, paying only code 97110. All other codes have been denied for no authorization. Looking at our records, the initial auth request was filled out entirely except for the CPT(s). ISN was unaware that all 'future treatment' codes were to be listed, nor did IMO come forward to say the form was incomplete or did the form mention to list ALL codes that will be billed. Not sure how we would know what treatment the Therapist was going to perform in advance?"

Amount in Dispute: $655.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "a preauthorization request was received by IMO . . . CPT code 97110 was approved for 12 sessions (3xweek for 4 weeks) . . . we received date of service 6/30/15 for Evaluation and PT. The Evaluation for this date was denied due to lack of G codes with modifiers, and the PT session for this date was denied for no preauthorization. . . . On 10/5/15 we received a 'corrected bill' which included the required G codes with modifiers. Payment for the evaluation was issued on 10/13/15 . . . We, however, maintained denial for the therapy session for this date, due to lack of preauthorization. . . . we received PT charges for date of service 7/15/15 . . . date of service 7/21/15 and . . . date of service 8/4/15. Payment was issued for these three bills, but only for CPT code 97110, as this was the only code authorized. Other therapy services billed for these dates were denied due to lack of preauthorization. The evaluation rendered on 8/4/15 was denied for lack of G codes with modifiers. . . . It is our position that payment issued was correct based on preauthorization obtained by Industrial Solutions Network and no further reimbursement is due for the therapy sessions. The evaluation rendered on 8/4/15 can be considered for payment if the provider re-bills (timely) with the required G codes and modifiers."

Response Submitted by: Claims Administrative Services, Inc.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 30, 2015 to August 4, 2015	Physical Therapy Services	$655.13	$277.92

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.600 sets out the rules for preauthorization of services.
3. 28 Texas Administrative Code §134.203 sets out the fee guideline for professional medical services.
4. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 16 – CLAIM/SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION. DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION.
   - 197 – PRECERTIFICATION/AUTHORIZATION/NOTIFICATION ABSENT.
   - P12 – WORKERS' COMPENSATION JURISDICTIONAL FEE SCHEDULE ADJUSTMENT.

Issues

1. Under what authority is the request for medical fee dispute resolution considered?
2. Did the respondent support denial of payment for lack of information needed for adjudication?
3. Did the insurance carrier authorize the disputed services?
4. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is a health care provider that rendered disputed services in the state of Arizona to an injured employee with an existing Texas Workers' Compensation claim. The health care provider was dissatisfied with the insurance carrier's final action. The health care provider requested reconsideration from the insurance carrier and was denied payment after reconsideration. The health care provider has requested medical fee dispute resolution under 28 Texas Administrative Code §133.307. Because the requestor has sought the administrative remedy outlined in 28 Texas Administrative Code §133.307 for resolution of the matter of the request for additional payment, the Division concludes that it has jurisdiction to decide the issues in this dispute pursuant to the Texas Workers' Compensation Act and applicable rules.

2. The insurance carrier denied disputed evaluation code 97001, date of service June 30, 2015, and re-evaluation code 97002, date of service August 4, 2015, with claim adjustment reason code 16 – "CLAIM/ SERVICE LACKS INFORMATION OR HAS SUBMISSION/BILLING ERROR(S) WHICH IS NEEDED FOR ADJUDICATION. DO NOT USE THIS CODE FOR CLAIMS ATTACHMENT(S)/OTHER DOCUMENTATION." The respondent states:

   > we received date of service 6/30/15 for Evaluation and PT. The Evaluation for this date was denied due to lack of G codes with modifiers, and the PT session for this date was denied for no preauthorization. . . . On 10/5/15 we received a 'corrected bill' which included the required G codes with modifiers. Payment for the evaluation was issued on 10/13/15 . . . The evaluation rendered on 8/4/15 was denied for lack of G codes with modifiers. . . . The evaluation rendered on 8/4/15 can be considered for payment if the provider re-bills (timely) with the required G codes and modifiers.

   28 Texas Administrative Code §134.203(b)(1) requires that for coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply "Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments

for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

Per Medicare payment policy, certain physical therapy services require the use of functional G-codes and appropriate modifiers with bills containing a defined set of CPT codes. Details of this CMS reporting requirement can be found at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM8166.pdf and http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM8005.pdf, and in the appropriate Medicare *Claims Processing Manual(s)* publicly available from the CMS website.

Review of the submitted documentation finds that the disputed evaluation codes were not reported with any of the required additional G codes and modifiers on the bills. The insurance carrier's denial for lack of information needed for adjudication is supported. Additional reimbursement cannot be recommended for these disputed evaluation services.

3. The insurance carrier denied disputed services with claim adjustment reason code 197 – "PRECERTIFICATION/ AUTHORIZATION/NOTIFICATION ABSENT."

28 Texas Administrative Code §134.600(c) states, in pertinent part, that the insurance carrier is liable for all reasonable and necessary medical costs relating to the health care listed in subsection (p) or (q), only when the following situations occur:

(A) an emergency, as defined in Chapter 133 . . .
(B) preauthorization of any health care listed in subsection (p) of this section that was approved prior to providing the health care;

28 Texas Administrative Code §134.600(p)(5) states that non-emergency health care requiring preauthorization includes:

physical and occupational therapy services, which includes those services listed in the Healthcare Common Procedure Coding System (HCPCS) at the following levels:
- (A) Level I code range for Physical Medicine and Rehabilitation, but limited to:
  - (i) Modalities, both supervised and constant attendance;
  - (ii) Therapeutic procedures, excluding work hardening and work conditioning;
  - (iii) Orthotics/Prosthetics Management;
  - (iv) Other procedures, limited to the unlisted physical medicine and rehabilitation procedure code; and
- (B) Level II temporary code(s) for physical and occupational therapy services provided in a home setting;
- (C) except for the first six visits of physical or occupational therapy following the evaluation when such treatment is rendered within the first two weeks immediately following:
  - (i) the date of injury; or
  - (ii) a surgical intervention previously preauthorized by the insurance carrier;

The submitted documentation does not support that the services occurred in an emergency or within the first 6 weeks following the injury or a surgical intervention, therefore the services required preauthorization.

No documentation was presented to support preauthorization for date of service June 30, 2015. This denial reason is supported. Therefore no reimbursement can be recommended for procedure codes 97530, 97110, and 97140 performed on June 30, 2015.

However, documentation was presented to support that preauthorization was requested and approved for dates of service July 15, 2015, July 21, 2015 and August 4, 2015.

The preauthorization determination letter states, "The request is for treatment in the form of 12 sessions of supervised rehabilitation services." The language in the approval section of the preauthorization letter does not limit the preauthorization of services to specific procedure codes. The approval language states: "IMO Physician Advisor . . . Physical Medicine/Rehabilitation has preauthorized medical necessity for 12 sessions (3 Times a week for 4 weeks) of Physical Therapy for Left Thumb to be done on an Outpatient basis."

While the portion of the letter that describes the requested services lists CPT code 97110, the approval language is not specific to a particular code.

Moreover, the section of the approval letter describing the "requested services" is not accurate. The original Pre-Authorization Request Form does not specify a particular procedure code. Consequently, the insurance carrier's listing of CPT code 97110 in the description of the "requested services" section constitutes a *change* in the elements of the pre-authorization request.

28 Texas Administrative Code §134.600(n) requires that "The insurance carrier shall not condition an approval or change any elements of the request as listed in subsection (f) of this section, unless the condition or change is mutually agreed to by the health care provider and insurance carrier and is documented." The submitted documentation supports that the insurance carrier changed elements of the preauthorization request to limit the scope of the requested services to procedure code 97110. The submitted documentation does not support that this change was mutually agreed to by the health care provider. Because the insurance carrier has not met the requirements of Rule §134.600(n), the carrier has waived the right to change the elements of the request or condition the approval on that change.

For the above reasons, the insurance carrier's denial for lack of preauthorization is not supported with respect to dates of service July 15, 2015, July 21, 2015 and August 4, 2015. Theses disputed physical therapy services will therefore be reviewed for payment according to applicable Division rules and fee guidelines.

4. This dispute regards professional medical services with reimbursement subject to the provisions of 28 Texas Administrative Code §134.203(c), which requires that:

   To determine the MAR [Maximum Allowable Reimbursement] for professional services, system participants shall apply the Medicare payment policies with minimal modifications.

   (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is $52.83 . . .

   (2) The conversion factors listed in paragraph (1) of this subsection shall be the conversion factors for calendar year 2008. Subsequent year's conversion factors shall be determined by applying the annual percentage adjustment of the Medicare Economic Index (MEI) to the previous year's conversion factors, and shall be effective January 1st of the new calendar year.

   The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. The applicable Division conversion factor for calendar year 2015 is $56.20. Reimbursement is calculated as follows:

   - For procedure code 97530, 2 units, service date July 15, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 1 is 0.53. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.877 is 0.00877. The sum of 0.97877 is multiplied by the Division conversion factor of $56.20 for a MAR of $55.01. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 50% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at $55.01. The PE reduced rate is $40.11. The total is $95.12.

   - For procedure code 97530, 1 unit, service date July 21, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 1 is 0.53. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.877 is 0.00877. The sum of 0.97877 is multiplied by the Division conversion factor of $56.20 for a MAR of $55.01. This procedure has the highest PE for this date. The first unit is paid at $55.01. Per §134.203(h), reimbursement is the lesser of the MAR or the provider's usual and customary charge. The lesser amount is $51.78.

- For procedure code 97140, 1 unit, service date July 21, 2015, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.43. The practice expense (PE) RVU of 0.4 multiplied by the PE GPCI of 1 is 0.4. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.877 is 0.00877. The sum of 0.83877 is multiplied by the Division conversion factor of $56.20 for a MAR of $47.14. This procedure does not have the highest PE for this date. The PE reduced rate is $35.90.
- For procedure code 97530, 2 units, service date August 4, 2015, the relative value (RVU) for work of 0.44 multiplied by the geographic practice cost index (GPCI) for work of 1 is 0.44. The practice expense (PE) RVU of 0.53 multiplied by the PE GPCI of 1 is 0.53. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 0.877 is 0.00877. The sum of 0.97877 is multiplied by the Division conversion factor of $56.20 for a MAR of $55.01. This procedure has the highest PE for this date. The first unit is paid at $55.01. The PE reduced rate is $40.11. The total is $95.12.

The total allowable reimbursement for the services in dispute is $277.92. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $277.92. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $277.92.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $277.92 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

	Grayson Richardson	February 26, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.